

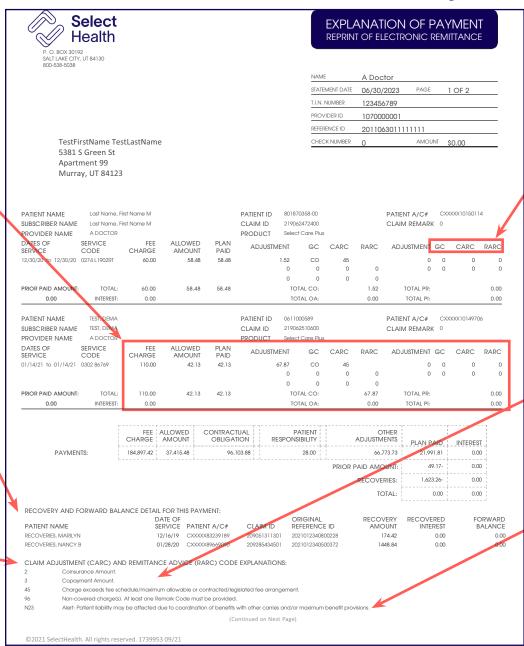
Select Health Remittance Advice Key

Reversal claim information will appear as negative dollars in the body of the RA. The recovery status of the claim will appear in the Recovery and Forward Balance Detail at the end of the RA Detail at the end of the RA.

A new claim will be processed to correct the mistake, and the new claim will list the reason for the correction.

Remember that only those claims where an actual recovery or reversal occurred on the current payment will appear in this section. Reversed or Pending Recovery claims with a remaining forward balance will not appear again until dollars are actually recovered.

This is a key to the current group codes used to indicate the type of adjustment being made to the claim line and to assist providers in determining who is liable for the adjusted dollars.



Group Codes (GCs), Claim Adjustment Reason Codes (CARCs), and Remittance Advice Remark Codes (RARCs) are the HIPAA-approved codes used to report dollars not paid to the provider for a particular claim.

This is a key to the CARCs, which communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there will be no adjustment reason code.

Common examples include:

- Deductible Amount
- Coinsurance Amount
- Co-payment Amount
- Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement

In some cases, an RARC will be supplied to further define the adjustment. Since the RARC is a supplemental code to the CARC, an RARC will never be reported without a CARC.